

## INTEGRATIVE HEALTH EVALUATION

### Background Information

Date \_\_\_\_\_ Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

### Health Concerns

	Concern (ex: PMS)	Onset (ex: age 14)	Symptoms (ex: moody, bloating, etc.)	Treatments (ex: B vits, acupuncture, etc.)
1				
2				
3				
4				

What are your goals for this visit?

1 \_\_\_\_\_  
 \_\_\_\_\_  
 2 \_\_\_\_\_  
 \_\_\_\_\_  
 3 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you have any allergies to medications, foods, pollens, etc.?

Allergen/Triggers (medication, food, etc.)	Reaction

Do you have any disabilities? If so, please describe.  No  Yes

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever had surgery or had any injuries? (Include major dental work)

Surgery or injury	How treated	When

List any prescription medications you are taking

Medication	Reason for taking	Dose/Times per day	Year started	Side Effects

List any over the counter medications you are taking

Medication	Reason for taking	Dose/Times per day	Year started	Side Effects

List any herbs, supplements or vitamins you are taking (Give brand)

Medication	Reason for taking	Dose/Times per day	Year started	Side Effects

### Use of Complementary or Alternative Therapies

Type	Never tried	Tried	Use currently	Not for me	Interested in
Massage					
Acupuncture					
Chinese herbs					
Other herbs					
Homeopathy					
Chiropractic					
Osteopathy					
Nutrition					
Mind-body (Hypnotherapy, Biofeedback, etc.)					
Reiki					
Other energy therapies (healing touch, polarity, etc.)					
Ayurveda					
Others					

### Substance Use History

- How much alcohol (beer, wine, liquor) do you drink –  
each day? \_\_\_\_\_ each week? \_\_\_\_\_ None
- How much tobacco (cigarettes, cigars, pipe, chewing tobacco) do you use –  
each day? \_\_\_\_\_ each week? \_\_\_\_\_ None
- How much caffeine (cola drinks, coffee, strong tea) do you drink –  
each day? \_\_\_\_\_ each week? \_\_\_\_\_ None
- Do you currently use drugs? (ex. Marijuana, cocaine, crack, heroin, speed, ecstasy, etc.)  
 No  Yes      What kind and how often? \_\_\_\_\_
- In the past?  No  Yes      How long ago? \_\_\_\_\_  
What kind and how often? \_\_\_\_\_
- Does anyone in your family have problems with drugs or alcohol?  No  Yes
- Who? \_\_\_\_\_
- Have you been in a drug or alcohol recovery program?  No  Yes
- Do you want to quit using tobacco, alcohol or drugs?  No  Yes
- Would you like advice, support or medicine to help you quit?  No  Yes



### Family History

Problem	Do you have now or in the past?	Family member has had? (list who)	How treated?
Heart disease			
High blood pressure			
Stroke			
Cancer			
Diabetes			
High cholesterol			
Mental health problems (ex. Depression)			
Colon polyps or colon cancer			
Other problems			

Were you adopted?  No  Yes

If so, do you have any medical knowledge about your biological family?  No  Yes

Are there any medical conditions that run in your family?

Problem	Family Member(s)

### Health Status of Immediate Family

Family Member	Age	Health Problem
Mother		
Father		
Siblings		
Children		
Spouse/Significant Other		

**Preventative Health**

Do you participate in any physical activity or exercise? (ex. Walking, going to the gym, cleaning houses, sports, etc.)

Activity	Amount of time/day or week

Do you do any type of flexibility exercises such as Tai Chi, Yoga or stretching?  No  Yes

Do you do any type of resistance or weight training?  No  Yes

Are you interested in being more physically active?  No  Yes

What types of physical activity would you like to be involved in? \_\_\_\_\_

\_\_\_\_\_

What would you like to achieve from being physically active? \_\_\_\_\_

\_\_\_\_\_

Are there specific things that you do in order to maintain your health?  No  Yes

What are they? \_\_\_\_\_

\_\_\_\_\_

If you feel as if you are “coming down with something, are there specific things that you do or don’t do to take care of yourself?  No  Yes

What are they? \_\_\_\_\_

\_\_\_\_\_

Name three things you know you should be doing for your health but are not currently doing.

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

\_\_\_\_\_

### Nutrition History

Are you currently on a special diet?  No  Yes If yes, please describe: \_\_\_\_\_

Have you ever felt out of control of your eating habits?  No  Yes

Have you struggled with frequent vomiting, making yourself vomit or eating so little over periods of time that you or others were worried?  No  Yes

Your current Weight \_\_\_\_\_ Height \_\_\_\_\_ BMI \_\_\_\_\_

In the last year, have you experienced significant weight loss or gain?  No  Yes

If yes, please describe: \_\_\_\_\_

List all the foods you have eaten in the last 24 hours

	List foods/beverages	List foods/beverages
Breakfast Time eaten:  Where eaten:		
Lunch Time eaten:  Where eaten:		
Dinner Time eaten:  Where eaten:		
Snacks Time eaten:  Where eaten:		

Is this a typical day for you?  No  Yes If yes, please describe: \_\_\_\_\_

Who usually prepares your meals? \_\_\_\_\_

Do you usually eat alone or with someone? \_\_\_\_\_

What percentage of the food you eat is organic? \_\_\_\_\_%

Please check which column most accurately describes how often you consume a serving of the following foods/beverages

Servings of	None	1/week	3-5/week	2-3/day	3-5/day	5-9/day
6 oz water						
1/2 cup fruit or vegetable						
whole grain cereal, bread,						
brown rice, wheatberry, quinoa, oats						
beans/legumes						
green/black/white tea						
olive oil, canola oil, olives, avocados						
small handful of nuts						
4 oz soy protein (tofu, tempeh, soy milk)						
clove of garlic						
fish (salmon, tuna etc.)						
flaxseed						
small handful of seeds						
dark chocolate						
poultry						
dairy products						
white potatoes, rice or bread						
caffeinated coffee, cola						
diet drinks						
butter						
vegetable oil						
margarine						
something from a box with a long shelf life						
red meat						
alcohol						
fried foods						
sweets/candy						
fast food						

Are there any types of food that you crave?

Food	Why or When?

Are there any types of food that you do not eat?

Food	Why?

Do you have problems with any of the following?

Constipation  No  Yes      Diarrhea  No  Yes      Bloating/gas  No  Yes

**Social History**

Do you live with anyone? If so, who? Please include pets.

Name	Age	Relationship

Marital/Partner Status:

Past (ex. married twice) \_\_\_\_\_

Current (single, married, partnered, divorced) \_\_\_\_\_

With whom do you have the most significant relationship? \_\_\_\_\_

Closet? \_\_\_\_\_

Most problematic? \_\_\_\_\_

With whom do you share your feelings? \_\_\_\_\_

Who would you call for a favor? \_\_\_\_\_

Do you belong to a group or community? \_\_\_\_\_

Have you ever been in a support program for a medical condition?  No  Yes

Please describe \_\_\_\_\_

Do you have enough money to meet your needs?  No  Yes

What do you do with your time? (ex. work, school, care for home or children, etc.) \_\_\_\_\_

How much TV do you watch each day? \_\_\_\_\_ hours

Have you served in the armed forces?  No  Yes If yes, please give details \_\_\_\_\_

What interests/hobbies do you have? \_\_\_\_\_

Do you do any volunteer work?  No  Yes If yes, please describe \_\_\_\_\_

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## Abuse

Have you ever been abused emotionally (treated in a mean, nasty or cruel manner) by your partner or someone important to you?  No  Yes If yes, by whom? \_\_\_\_\_

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Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?  
 No  Yes If yes, by whom? \_\_\_\_\_

Are you afraid of your partner or anyone listed above?  No  Yes

If yes, of whom? \_\_\_\_\_

Would you like to discuss these things with me or someone else?  No  Yes

## Sexual Health

Do you have sex with:  Men  Women  No one

Age of first intercourse: \_\_\_\_\_ Number of partners in the past year: \_\_\_\_\_

What type of sex do you have?  Vaginal  Anal  Oral (Check all that apply)

Have you ever had sex with someone who...

has HIV?  No  Yes uses needles?  No  Yes is bisexual?  No  Yes

Do you use safer sex protection?  No  Yes

Do you use any form of birth control?  N/A  No  Yes If yes, what? \_\_\_\_\_

Are you happy with this method?  No  Yes

Have you ever used:

Condoms  The pill  Depo shot  Diaphragm  Cervical cap  Norplant  IUD

Spermicides  Withdrawal  Female condom  Natural family planning

Have you ever had:

Chlamydia  Gonorrhea  Genital Warts/HPV  Herpes  Syphilis  HIV

Are you happy with your sex life?  No  Yes \_\_\_\_\_

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If there was one thing you could change about your sex life, what would it be? \_\_\_\_\_

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Have you ever used any sexual enhancement drugs (Viagra, Levitra, Cialis, etc.) or herbals?

No  Yes Describe: \_\_\_\_\_

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## Women's Health History

Age periods began \_\_\_\_\_ Age periods stopped \_\_\_\_\_ Last menstrual period \_\_\_\_\_

How often do you get your period? \_\_\_\_\_ days. Is it regular?  No  Yes

How long does/did it last? \_\_\_\_\_ days

Do you bleed between periods?  No  Yes

Do you have bad cramps?  No  Yes If yes, are you able to manage your cramps?  No  Yes

Do you have premenstrual symptoms?  No  Yes Describe \_\_\_\_\_

Do you have menopausal symptoms?  No  Yes Describe \_\_\_\_\_

Do you have pain or bleeding with sex?  No  Yes

Any history of fibroids, endometriosis, ovarian cysts or other reproductive health problems?

No  Yes Describe \_\_\_\_\_

When was your last Pap smear? \_\_\_\_\_ Was it normal?  No  Yes

Have you ever had an abnormal Pap smear?  No  Yes When? \_\_\_\_\_

Results? \_\_\_\_\_

Did you have: (check all that apply)

Colposcopy \_\_\_\_\_ Treatment \_\_\_\_\_ Repeat Pap smears normal \_\_\_\_\_

When was your last mammogram? \_\_\_\_\_ Was it normal?  No  Yes

Have you ever had an abnormal mammogram?  No  Yes If yes, when? \_\_\_\_\_

Results \_\_\_\_\_ Where performed \_\_\_\_\_

Further testing \_\_\_\_\_

Do you have breast pain, discharge, skin changes or any other problems?  No  Yes

Have you had any breast surgeries?  No  Yes Describe \_\_\_\_\_

Have you ever had  Pelvic inflammatory disease (PID)  Frequent yeast infections

Frequent bacterial vaginal (BV) infections

Number of pregnancies \_\_\_\_\_ births \_\_\_\_\_ miscarriages \_\_\_\_\_ abortions \_\_\_\_\_  
living children \_\_\_\_\_

Any problems with your pregnancies?  No  Yes If yes, what? \_\_\_\_\_

Have you had problems getting pregnant?  No  Yes If yes, describe \_\_\_\_\_

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Do you have a family history of breast or ovarian cancer  No  Yes Who? \_\_\_\_\_

When was the last time a health care provider examined your breasts? \_\_\_\_\_

Do you have a family history of osteoporosis (weak or broken bones)?  No  Yes

If yes, who? \_\_\_\_\_

Have you ever had bone density testing? )?  No  Yes If yes, when? \_\_\_\_\_

Where \_\_\_\_\_ Results \_\_\_\_\_

**Emotional/Spiritual Health**

What are the major stressors in your life?

How would you rate your stress level in the past month? (Circle the appropriate number below)

1 2 3 4 5 6 7 8 9 10

Completely relaxed

Extremely stressed

What do you do to relax?

Where is your favorite place to relax?

**Relaxation methods**

Technique	Never tried	Tried	Use currently	Not for me	Interested in
Progressive muscle relaxation					
Meditation					
Visualization/Guided imagery					
Hypnosis					
Breathing exercises					
Yoga					
Tai Chi/Chi Gong					
Massage/body work					
Biofeedback					
Other:					

How would you rate your emotional state in the past month? (Circle the appropriate number below)

1 2 3 4 5 6 7 8 9 10

Very sad

Very happy

Have you ever been to a support program or therapist for emotional issues?  No  Yes

Do you have any phobias?  No  Yes If yes, please explain \_\_\_\_\_

Are there any other significant traumas (emotional, physical, etc.) that have affected you?  No  Yes

If yes, please explain \_\_\_\_\_

Please answer the following

Over the past two weeks, how often have you	None or little of the time	Some of the time	Most of the time	All of the time
been feeling low in energy, slowed down?				
been blaming yourself for things?				
had poor appetite?				
had difficulty falling asleep, staying asleep?				
been feeling hopeless about the future?				
been feeling blue?				
been feeling no interest in things?				
had feelings of worthlessness?				
thought about or wanted to commit suicide?				
had difficulty concentrating or making decisions?				

What are your sources of hope or strength when things are difficult?

\_\_\_\_\_

\_\_\_\_\_

Are you part of an organized religion?  No  Yes Describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is religion or spirituality important to you?  No  Yes If yes, in what way? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have a personal spiritual practice?  No  Yes Describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there anything else about your health you think I should know? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_